EMPLOYER STATEMENT

Incapacitation Pay Requested For The Period : _____thru_____

EMPLOYEE RELEASE:

I,_____, _____

(Employee's Name-Typed/Printed) (SSN)

hearby authorize the release of the information requested below:

_____ _____

(Employee's Signature) (Date)

EMPLOYER CERTIFICATION (TO BE COMPLETED BY EMPLOYER ONLY):

1. Date employee hired: _____.

2. Position and Description of Duties:_____

_____

3. Has the employee worked any days since his/her injury? YES_____ NO_____. If YES, please list dates and number of hours worked: _____

_____

4. **During the period indicated above**, the amount of **GROSS** compensation (wages, tips, commissions, etc.) **PAID** to employee was $_____.

5. **During the period indicated above**, the amount of sick/advance sick leave, vacation pay, or income protection benefits **PAID** to employee was $_____.

6. **During the period indicated above**, employee lost: $_____.

7. I understand this information is being used by the claimant as the basis of a claim against the United States Government. I further understand that knowingly and willfully assisting a claimant making a false claim or false statement in connection with a claim, is a criminal offense, under Federal and State laws, which may subject the parties to a substantial fine and/or lengthy imprisonment.

Supervisor's Signature _____Date _____

Supervisor's Name (printed/typed) _____

Supervisor's Tel. Number and Extension _____

Company Name _____

Company Address (including ZIP Code) _____

_____